ORIGINAL ARTICLES

Scientific and General

THE FUTURE OF MEDICINE FROM THE STANDPOINT OF A PHYSICIAN IN PRACTICE*

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THIS short talk will be divided into three sections:

1. What we want.
2. What we—and society—have to offer for the care of the sick.
3. What are we likely to get, and why.

I. WHAT WE WANT—AND WHAT WE DO NOT WANT

We want for the public the best medical care—the sick person is the first consideration; for ourselves, primarily, to be left alone to work the problem out.

We want changes to be made by the profession; we want not to be told what to do by legislators, theorists, welfare workers, hospitals. We know far more about needs, intricacies and difficulties, than any other group. Our reluctance to make rapid changes has been because of this knowledge. We need to be given time to work out our own plan. We want nothing like compulsory health insurance without free choice of physicians. A history of sixty odd years of health insurance in Europe is not convincing. We want the government not to install a system depending on trial and error for guidance. We want hospitals and nurses to be subordinate to physicians. We do not want politicians, or exploiters, using the medical profession for their own ends at the expense of the sick. We want the patient-physician relationship unimpaired.

All these things we want, and no doubt much more.

Now, what have we, the physicians, to offer except for those who come to our offices and pay? And what does the rest of society provide for the care of the sick?

Remember, when this Society was started there were no specialists, and few and imperfect hospitals; and contract care for the destitute sick was rudimentary.

We had only the general practitioner.

The doctor-patient relationship was unimpaired.

Since then, society has gone a long way in good and bad.

Let me comment on some of the various systems of caring for the sick.

II. WHAT WE HAVE

Let us examine private practice of medicine and the departures therefrom:

The Private Practitioner, Practicing Alone:

In small communities he is often a leader, and the "true physician" if he is the right kind. He is more self-reliant and versatile than his confrères in larger cities, and can do a creditable job in several specialties. He is often a far more effective man than the metropolitan specialist, who is unable to exercise judgment outside his own specialty.

In larger cities, the physician depends on a number of other physicians. If he is conscientious, he refers patients, when that is necessary, to specialists selected for the patient's needs, both scientific and practical. This system is wasteful of time and money.

Group Practice:

This is theoretically the best form. It depends on the skill, character, and self-restraint of the members of the group. I have never known a group of any value which did not have a capable and judicious leader, who could evaluate the idiosyncrasies of his team members, as well as those of the patient.

Private practice and group practice make possible abuses, such as overtreatment, unnecessary operations, overcharging, salesmanship generally.

Practice by Government Agencies:

Before this war, 65 per cent of hospital beds in this country were said to be in Government hospitals.

U. S. Public Health Service:

I would say that treatment of patients is generally good and considerate. The patients are usually such as would not readily contact private physicians.

The Army and Navy:

Normally the medical departments give me the impression of tolerating the patients, as an evil necessary to the department's existence. If statistics were available to indicate patient day costs, which they may be, I would expect them to show prodigious waste of resources.

Whatever good reputations the medical departments of the Army and Navy are making for history, and with the soldiers and sailors, will be due to the reserve officers. I hope that the soldiers and sailors will remember that, if ever they have a say about the kind of medical care they want.

State Medical Care and City or County Medical Care:

You are near enough to these to know the pictures. No special comment is offered.

Prepaid Medical Care with No Free Choice of Physicians:

Example.—The Ross-Loos Clinic, appears to give fairly adequate care, but is distasteful to us, principally because it is an exploitation of physicians by physicians. Approximating this is the Kaiser medical service, referring, however, only to employees. Mr. Kaiser's resources permit excellent equipment, and he is happy in his choice

* Read before the San Francisco County Medical Society, November 7, 1943.
The opinions and assertions contained herein are the private ones of the writer.

of physicians. There is no difference between this service and others with which we have been familiar for years, in the mining, railroading, lumbering, shipbuilding and other industries. Patients have not free choice of physicians. Up to date, comparable service could not have been secured, except from such an organization as California Physicians' Service. With the lack of resources, youth, and sabotage, with which California Physicians' Service has had to contend, it is doubtful if California Physicians' Service could have provided the care.

Prepaid Medical Care—Free Choice of Physicians:

We have insurance companies; effectiveness is limited and uncertain. Insurance companies can, on a straight insurance basis, reimburse for medical expense in a manner comparable to insurance on anything.

California Physicians' Service:

This, as all similar enterprises, is actually in the early experimental stage. No insurance company—and experience must be gained by California Physicians' Service, as by an insurance company—is expected to have a chance to survive until it has operated for seven years, and has $7,000,000 of insurance in force, and 95 per cent of these which attain that, *fail.*

It is most unfortunate that we must have a world war to interfere with an orderly and gradual growth and experience.

It is tragically lamentable that we cannot have loyalty and patience and understanding in the whole medical profession of California. The self-sacrifice, devotion, and time expended by a few of your fellow members, for California Physicians' Service and for you, are far beyond belief or possibility of compensation. Of all efforts of the medical profession to avert state medicine, such projects as California Physicians' Service promise the most.

State Medicine:

You must be more or less familiar with the "57 varieties" of state medicine in existence at last reports. Most of the important countries of the world had state medicine, in some form. No two were alike, the best reason for which is that none was satisfactory. At last report, Germany's system—the oldest—reported that absence due to sickness increased 40 per cent. Physicians' incomes were so meagre that suitable young men would not study medicine. England did not wish to abolish her system, but hoped it could be much more satisfactory, yet did not know how it could be improved. The Britons had no such hospitalization system as we would think essential.

This country never adopted state health insurance, because the people naturally want to be independent. Lately, that attribute is being worn down—unless recent elections mean something.

Still—"What We Have":

Lay bodies, social reformers, economists, etc.—all striving for means to control the practice of medicine—all *more* interested in putting something *over* than in the welfare of the sick human being. The Wagner-Murray bill provides for control of the whole problem by the U. S. Public Health Service. Doctor Parran told me that he had no inkling of this bill until it was shown to him the day before it was introduced. He said he would have none of it. The Public Health Service views it with horror. The bill is probably too great a bite to take all at once, and therefore will defeat itself. It is another example of an effort to attain fulfillment of a delightful dream without knowledge of the obstacles in the path.

I cannot leave consideration of "what we have" without reference to the Workmen's Compensation Laws (California's especially). The California law has attributes comparable to state health insurance. This law went into effect thirty years ago. It has been modified, altered, amended, not because of changing conditions, but because it was not perfect. It is not perfect yet. It was at first administered by high-minded men. It has been from time to time dominated by politics and administered in a manner quite contrary to its intent, and the wishes of the people.

And, we have the American Medical Association.

Possibly if the American Medical Association had known of a good health insurance plan, or prepayment plan, it would have approved. However, the Association permitted it to be believed that it was unalterably opposed to all such ideas, and thereby gave comfort to the enemy. It was a major tactical blunder to permit this impression to exist, whether the American Medical Association felt that way or not.

If California Physicians' Service had started five years earlier, which it might have done but for shortsighted opposition within our profession, we would now have an experience of great value, and would now have stability. However, no normal experience can prepare any enterprise for the distortions caused by the greatest of all wars.

In this connection it would be well to remember that twenty-five and again fifteen years ago there were determined efforts in California to put over state health insurance. It was attempted by economists and others, and no physicians had any part in it except that of opposition. In the bill prepared for the legislature, in the first attempt, $11.00 was the estimated cost per person per year. I remonstrated with the executive officer of the commission saying that three times that sum would be more nearly correct. The doctor (Ph.D.) blandly told me that the bill would never pass with that estimate, but if it were passed, it could be adjusted. See if that means anything to you.

III. WHAT WE ARE LIKELY TO GET

What we are likely to get will *not* be what we want. The revelation of what we have is not a convincing background for going after what we want. The capacity of the human mind has not increased, to judge from history, since history began. Yet there are a hundred times more items

(let us assume the 100) to know than there were 150 years ago. If we know ten times more than our ancestor, we still know one-tenth as much as he did of what there is to know and are relatively ignorant. There was a time when an erudite man, Benjamin Franklin for instance, knew a substantial amount of all there was to know. That is impossible now,—no such men—no adequate mental capacity—no time.

Imperfect knowledge leads to interference in our affairs by fanatical theorists whose imaginations are not trammeled by modifying information. We are aware of the reluctance of the best-informed to be positive vs. the readiness of the partially-informed to be positive. Apparently the control goes to those who have the hardihood to accept responsibility, though uninformed. We are confronted by the results of this condition of mind. Central control is spreading. We are likely to get health insurance legislation. The medical profession and American Medical Association have done nothing effective to indicate that they can offer what the social reformers want.

Of course, those promoting legislation have something in mind besides the care of the sick. It may be another bureau, more government employees, or gratification of a grand desire to dominate the medical profession. The *people* do not *demand* health insurance, though some provision for medical care would be beneficial. They will no doubt accept it and take advantage of it, if it is provided.

The medical profession will not long be able to stem the tide of health insurance, unless it can present a united front and offer a plausible alternative. In this the profession is handicapped because it must limit statements to truth, whereas the visionaries may devise any attractive plan—unhampered by experience.

It may be too late now for the profession to get together. If not, it is because of war—and we have another chance.

Some physicians will continue to practice much as they do now, as long as there are economic groups to serve. There will be an increase in the formation of balanced clinical groups. That system is more economical and scientific.

There will be increase of subscribers in prepayment plans. I expect development of state plans such as California Physicians' Service generally —over the country. Such a spectacle would go a long way to check compulsory health insurance. Let the Government pay to California Physicians' Service the fees for certain groups; for instance migrants, unemployed. If a prepayment plan—organized by the profession supported by the profession—existed in every state, there would be no Wagner bill. I doubt if we would be much bothered by legislation.

You are reminded in this short sketch that the practice of medicine has altered drastically in seventy-five years. Far more in its mechanics than in its scientific aspects, though those have changed more in that time than in all the previous history of medicine.

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TUBERCULOSIS IN WAR TIME*

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INTRODUCTION.—We are all familiar with the striking decline in tuberculosis mortality which has taken place since the beginning of the century, a drop from 200 per 100,000 to approximately 45, a reduction of 77 per cent. History fails to record a greater public health achievement. The temptation now is to lean on our oars, feeling that the disease is finally and completely on the run.

A little reflection, however, is not reassuring, for the white plague still remains the leading cause of death in the age group 15 to 45, the productive period of life. Somewhat paradoxically, this fact has led to the optimistic and widespread idea that tuberculosis is essentially a disease of premiddle life, and that, after the age of say 45, it can be ignored. Sad experience has taught us that this is far from being the case. If we segregate our age groups to show the death rates from tuberculosis per 100,000 living persons *in each such group,* we find that the mortality rate continues practically unchanged from middle life on up to the eighth decade. Tuberculosis among older people is one of our most serious problems at the present time, and many of our clinical cases in younger persons are due to infection contracted from a parent or grandparent whose tuberculosis is frequently unsuspected, being masked as a chronic bronchitis, asthma or heart disease.

On the whole, however, we have reason to feel hopeful about the general situation. Progress in our knowledge of the disease has been great, and progress in treatment has been correspondingly rapid. We are still lacking in definite information regarding many of the factors which have to do with the resistance of tissues to the inroads of the tubercle bacillus, but the search continues, with sufficient results to keep alive the spark of hope. We believe that cellular and tissue nutrition is the cornerstone. From the immense agglomeration of data on food groups, on calories, minerals and vitamins, there is gradually emerging a semblance of order and a modicum of knowledge.

MECHANICAL ELEMENTS

The importance of the mechanical elements involved in this disease has impressed itself on all who are called to treat it.

It seems elementary to emphasize the importance of adequate drainage from infected areas. Yet it is only recently that the bronchoscope has revealed to us the frequency with which such drainage is impaired, and has shown us when to suspect the presence of obstructive bronchial lesions. Many phases of pathology heretofore

* Read before the Section on General Medicine, at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.